U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 26 August 2005

Case No. 2005-LHC-576

In the Matter of:

Mark A. Patterson,
Claimant

v.

Electric Boat Corp.,
Employer

DECISION AND ORDER AWARDING BENEFITS[1]

This proceeding involves a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, *et seq.* [hereinafter "the Act"]. A hearing was scheduled for May 4, 2005 in New London, Connecticut, but was cancelled after the parties agreed to a hearing on the record. I issued an order setting a schedule for the submission of exhibits on May 5, 2005, granting the parties 10 days to submit evidence and objections to the opposing party's exhibits. Mr. Patterson [hereinafter "the Claimant"] submitted four exhibits on May 11, 2005. Electric Boat [hereinafter "the Employer"] also submitted four exhibits on the same date. No objections were received to any submissions. On May 23, 2005, I issued an order closing the record and giving the parties thirty days to submit briefs. The Claimant filed his brief July 7, 2005; the Employer filed its brief July 8, 2005. I have reviewed and considered these briefs in making my determination in this matter.

Statement of the Case

Background

The Claimant is a 39 year-old left-handed man who works out of Union Local 1122 in New London, Connecticut as a painter and taper. (EX 1 at 1) He is married. (EX 1 at 4) He finished the ninth grade in school and can read and write satisfactorily. (EX 1 at 4) Mr. Patterson worked for Electric Boat in Groton, Connecticut, from 1991 until 1995, when he was laid off. (EX 1 at 3) He used needle guns, burr tools, disk

[1] Citations to the record of this proceeding will be abbreviated as follows: "Tr." refers to the Hearing Transcript; "ALJ" refers to the Administrative Law Judge's Exhibits; "CX" refers to Claimant's Exhibits; and "EX" refers to Employer's Exhibits.

sanders, and sandblasting pressure hoses for 6.5 hours a day. (EX 1 at 3) Since then, he has worked for Local 1122 as a union painter and taper. (EX 1 at 3) He also worked for Millstone and did some needle gun and sandblasting work. (EX 1 at 3)

Mr. Patterson had worked at Electric Boat as a painter/sandblaster for about four years when he began noticing pain over his left wrist, lateral left elbow, posterolateral right elbow and right wrist. (EX 1 at 1) He also noted numbness of his left hand. (EX 1 at 1) These symptoms came on gradually. (EX 1 at 1) After he went through surgery in 2003, he continued to have some numbness over both medial elbows. (EX 1 at 1)

Claimant reported his symptoms to the yard hospital when he first began noticing them, in 1994 or 1995. (EX 1 at 1) At that time, he was examined, prescribed Ibuprofen and advised to use wrist bands. (EX 1 at 1) Several months later, he was laid off. (EX 1 at 2)

Dr. Cherry primarily treated the Claimant, performing x-rays, electrical testing, and eventually surgery on his wrists and elbows. The surgery provided some improvement to his right side, but no improvement to his left side. One year later, Dr. Cherry advised the Claimant that all treatment options had been exhausted.

Approximately four years ago, Mr. Patterson traumatically partially amputated his left index finger on a wood splitter at home. (EX 1 at 3)

Currently, Mr. Patterson takes Ibuprofen twice a week for his numbness, but overall is unimproved. (EX 1 at 2) He continues to have numbness, tingling, weakness and decreased strength in his upper extremities. Gripping, writing, lifting, repetitive wrist motion, tool usage, and working in the cold all aggravate his hand pain. (EX 1 at 3) He obtains relief by shaking, hanging, and rubbing his hands. (EX 1 at 3)

Medical Evidence

Dr. Thomas C. Cherry

Dr. Cherry started seeing Mr. Patterson on August 31, 1995. (CX 1 at 10) Mr. Patterson complained of numbness in his hands and proximal forearms and pain involving the lateral aspect of the elbow and proximal forearm on the left in the lateral epicondylar area. Before seeing Dr. Cherry, Mr. Patterson had been using splints and anti-inflammatories.

Dr. Cherry's examination of the Claimant showed a positive Tinel's sign at the wrist with symptoms extending out to the ulnar aspect of the hand, with Tinel's negative at the elbow. The forearm compression test was positive bilaterally with symptoms diffuse in the hand. There was no muscle wasting, and range of motion was full and complete. There was no focal tenderness to palpation at the lateral epicondyle on the left, where the Claimant reported experiencing the most severe pain. Dr. Cherry assessed Mr. Peterson with some cumulative trauma disorder to the hands, probable Carpal Tunnel

Syndrome, and probable Canal of Guyon level ulnar compression. He felt that the Claimant also probably had a mixed tendonitis-synovitis picture and some component of vibratory tool disease or damage, as he was cold sensitive and his job involved the use of vibratory tools.

Dr. Cherry concluded that Mr. Patterson had Cumulative Trauma Disorder in the form of Carpal Tunnel Syndrome with some ulnar nerve compression, and a component of vibratory tool distal or axonal damage to his hands and fingers. Dr. Cherry believed that these conditions arose directly, causally, and solely out of Mr. Patterson's work at Electric Boat as a painter.

Mr. Patterson returned to Dr. Cherry five and half years later on February 22, 2001. (CX 1 at 9) After Dr. Cherry saw Mr. Patterson in October 1995, nerve conduction studies were returned as negative. The Claimant had since left Electric Boat, but his symptoms continued. After leaving Electric Boat, Mr. Patterson worked as a painter and sheet rock taper through his union. During this time, while he did not develop new symptoms, the symptoms in his hands increased. He was no longer able to sleep through the night due to the constant and significant numbness, tingling and aching in his hands. On examination of the Claimant, Dr. Cherry found a positive bilateral Tinel's sign, forearm compression test and Phalen's test. His problems were primarily in his wrists, left greater than right, and pain in his elbow, for which Dr. Cherry had already recommended an orthopedic referral. Dr. Cherry believed these symptoms were an extension and continuation of the problems that arose while the Claimant worked at Electric Boat. Dr. Cherry felt surgical release was necessary.

On November 25, 2002, the Claimant returned to Dr. Cherry after having nerve conduction studies and an examination by Dr. Wainright. (CX 1 at 8) He wished to proceed with surgery. His nerve conduction studies and EMGs revealed radiculopathy at the C7 level. Dr. Cherry also felt Mr. Patterson had some degenerative changes in his dorsal radial wrist. Dr. Cherry noted some pain, fullness over the radiocarpal area and tenderness with motion that was not present in 1995. He decided to proceed with surgery only on the Claimant's right side because the problems on the left were not related to the carpal tunnel syndromes per se, and may not have been related to his prior work at Electric Boat or his then current employment. Dr. Cherry decided to proceed with a right carpal tunnel and Canal of Guyon release, and he expected substantial relief for the Claimant.

On April 10, 2003, Mr. Patterson returned and reported that he was doing well post-surgery. (CX 1 at 7) Examination revealed well-healed scars, full and complete range of motion, and less than usual soreness. The Claimant wished to proceed with surgery on the left. Dr. Cherry reported that the cause for the problems on the left was the same as for the right.

On May 13, 2003, Mr. Patterson underwent a left ulnar nerve transposition at the elbow and a left carpal tunnel and Canal of Guyon release. (CX 1 at 6) He followed up with Dr. Cherry May 15, 2003. Dr. Cherry noted that Mr. Patterson was slower to

recover from the anesthesia, and he removed Mr. Patterson's dressings. Mr. Patterson inquired about the arthritic-degenerative changes in his dorsal radial left wrist. Dr. Cherry recommended he seek treatment from Dr. Korcek for this ailment.

A May 22, 2003 notation notes Mr. Patterson continued to do well, with sutures taken out at his palm. (CX 1 at 6) His range of motion was excellent to date.

On May 29, 2003, Mr. Patterson returned for a follow up. (CX 1 at 5) Examination revealed good symptom relief. Dr. Cherry returned him to work, and took him off of his disability status for two weeks. Dr. Cherry also discussed the Claimant's wrist problems with him, stating that, based on statements made by Dr. Wainright, Dr. Korcek would be better able to determine if this injury was also work-related.

On July 3, 2003, Mr. Patterson returned for a follow up. (CX 1 at 5) By that time, he had returned to work and reported that he was doing well. Dr. Cherry clarified that Mr. Patterson's left hand had been healing well, but the complaints in the hand and elbow persisted. He still experienced numbness, tingling, and aching, and awakened from sleep due to these sensations. While he had significant, but not total, relief on the right, his relief on the left was not equivalent. The C-7 level findings on his nerve conduction study and problems with his wrist persisted.

On October 2, 2003, Mr. Patterson returned, reporting gradual improvement of his right arm, continued numbness around his left elbow, and numbness and aching in his left wrist that extended to his fingers. (CX 1 at 4) Examination revealed point tenderness and sensitivity at the elbow. His transposed nerve segment was sensitive, and there was a positive Tinel's sign above the medial epicondyle. His primary area of sensitivity was posterior to the medial epicondyle area of release of the inter muscular septum, which was quite sore. Because Dr. Cherry had not seen patients with this area of discomfort or post-operative pain, he recommended that the Claimant get a second opinion from Dr. Wainright.

On December 18, 2003, Mr. Patterson returned, having missed his appointment with Dr. Wainright. (CX 1 at 4) He claimed he was not informed of the appointment. Examination revealed relief of the significant tenderness and pain on his left arm, at the olecranon area. Significant dense hypothesia around the elbow remained. While his right side had recovered excellently, his left side was still weaker. Dr. Cherry noted smaller radial and median enervated muscles on the left forearm which he attributed to disuse atrophy. Dr. Cherry decided to forego the second opinion; he reported that Mr. Patterson continued to work full-time.

On March 18, 2004, Mr. Patterson reported that his right side continued to do better than the left. (CX 1 at 2) However, Mr. Patterson maintained that he was not able to perform old activities—such as push-ups—due to the pain and weakness in both hands, elbows and arms. Examination revealed an area of persistent marked hypoesthesia of approximately 6 cm in diameter, distal to the medial epicondyle on the right. The median nerve by Tinel's sign overlying the nerve itself and the muscle were tender. Mr.

Patterson reported that when he used his arm, he experienced an internal ache along the ulnar aspect. He also experienced ongoing significant cold intolerance on both sides, including the hands.

Dr. Cherry reported that the Claimant's right side had symptomatically and substantially improved. However, the left arm still exhibited significant symptoms that awakened Mr. Patterson during the night. He also had a significant loss of proximal forearm muscle mass, particularly in the flexor carpi ulnaris. The left arm contained a much greater area of dysesthesia and hypoesthesia representing antebrachial cutaneous nerve loss. Dr. Cherry planned to obtain nerve conduction studies and EMGs .

On May 13, 2004, Dr. Cherry reported that Mr. Patterson had continued positive Tinel's sign at both elbows, grossly evident decreased forearm muscle bulk, and decreased grip strength, extensive on the left and focal on the right. (CX 1 at 1) Nerve conduction studies showed persistent irritation on the left. Functional examination revealed ready fatigueability and exhaustion in both upper extremities left greater than right, and discomfort with any use, particularly overhead use. The nerve studies showed C-7 radiculopathy on both sides.

Taking into account the sensory losses, decreased grip, anatomic disruptions in both the carpal tunnel and Canal of Guyon releases at the hand level and the ulnar transpositions on the right with the area of sensory loss in the forearm, Dr. Cherry concluded that Mr. Patterson had a 9% permanent partial disability rating to the right upper extremity as a whole. On the left, given the greater complaints and findings, Dr. Cherry assessed a 14% permanent partial disability. He stated that further surgery was not recommended, as the possibility for improvement was poor and the risks outweighed the potential benefits.

Dr. Philo F. Willetts

Dr. Willetts, who is a board-certified orthopaedist, examined Mr. Patterson on September 16, 2004, and prepared a report at Employer's request. (EX 1) Dr. Willetts reported Claimant's occupational and medical histories.

On examination of the Claimant, Dr. Willetts noted healed surgical scars over the ulnar aspects of Claimant's elbows. The areas adjacent to the surgical scars had decreased pinprick sensation. (EX 1 at 5) The Claimant's elbow motion was full, with full extension, flexion, pronation and supination, but his cubitus valgus elbow angulation was abnormal bilaterally, measuring 16 degrees on the right and 17 degrees on the left. (EX 1 at 5)

Inspection of Mr. Patterson's hands revealed well healed surgical scars over both carpal tunnels. (EX 1 at 5) Dr. Willets noted no atrophy, edema, discoloration, or vascular dilatation. (EX 1 at 5)

Phalen's carpal tunnel tests were positive at 15 seconds on the right and 10 seconds on the left. (EX 1 at 5) Carpal compression test reported positive at 5 seconds on the right, but negative on the left. (EX 1 at 5) Elbow flexion tests were reported positive at 25 seconds on the right and 15 seconds on the left. (EX 1 at 5) Mr. Patterson had positive Tinel's nerve irritation signs over both median nerves at the carpal tunnels and ulnar nerves at the medial elbows. (EX 1 at 5)

Mr. Patterson had slightly decreased muscle strength with good effort on the right and mildly decreased on the left. (EX 1 at 6) He exhibited no abnormal Froment's sign and no abnormal weakness of thumb or index finger flexion. (EX 1 at 6)

Sensory examination revealed slightly prolonged Semmes Weinstein monofilament light touch sensation over the previously traumatically amputated left index fingertip. (EX 1 at 6) Pinprick sensation was decreased over the right ring finger, left small finger, the left thumb/index finger web space, and over the radial aspect of the left forearm and the medial aspect of both elbows at the surgical sites. (EX 1 at 6) Objective deep tendon reflexes were normal. (EX 1 at 6)

Dr. Willetts also reviewed the Claimant's medical records, noting the normal and abnormal test results.

Dr. Willetts concluded that Mr. Patterson had ongoing bilateral mild neuropathy, probably substantially vibration related, status post multiple nerve releases. (EX 1 at 11) He also noted an electrically suggested left C7 nerve root disorder, with no supporting clinical symptoms or abnormalities. (EX 1 at 11) Dr. Willetts acknowledged that in cases of substantial vibration contribution to neuropathy, the results of surgical releases are poorly predictable. (EX 1 at 12)

Relying on *The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*, Dr. Willetts concluded that Claimant has a 6% permanent partial impairment of the right upper extremity, with 4% attributed to his sensory impairment and 2% to his muscular impairment.[2] Dr. Willetts assigned a 9% permanent partial physical impairment of Mr. Patterson's left upper extremity, with 6% attributed to a sensory impairment and 3% attributed to his muscular impairment.[3]

Dr. Willetts believed that in addition to Mr. Patterson's employment, his smoking, drinking of alcohol and increased weight contribute to his right-sided impairment. Of the 7% permanent partial physical impairment of the right hand, he apportioned 5% of the impairment to the Claimant's work activities at Electric Boat.

[2] Using Table 16-2 on page 439 of the AMA Guides, Dr. Willetts stated that this is the equivalent of a 7% permanent partial physical impairment of the right hand.

[3] Using Table 16-2 on page 439 of the AMA Guides, Dr. Willetts stated that a 9% left upper extremity impairment is equivalent to a 10% permanent partial physical impairment of the left hand.

Dr. Willetts believed that Mr. Patterson could return to his full duty, but advised that he should avoid further exposure to vibrational tools. Dr. Willetts was unaware of any previous conditions that contributed to the Claimant's current condition.

Dr. William A. Wainright

Mr. Patterson submitted the record of Dr. Wainright's medical examination dated June 11, 2002. (CX 4 at 21) Dr. Wainright reported Mr. Patterson's employment history, noting that he was laid-off from Electric Boat in 1996 and that he currently works in industrial painting, which requires repetitive wrist motion and power grip. (CX 4 at 21)

On examination of Mr. Patterson, Dr. Wainright noted good use pattern of the hands with no loss of soft tissue bulk in the distal segments. Mr. Patterson exercised normal range of motion, with the exception of the partially amputated left index finger. The cubital tunnels revealed an equivocal Tinel's sign, but a positive elbow flexion test bilaterally. Mr. Patterson's Tinel's sign over the carpal tunnel and Phalen's test were positive. Dr. Wainright noted swelling over the dorsal aspect of the left wrist in the radial scaphoid area and decreased range of motion of the left wrist compared to the right side.

Dr. Wainright performed various sensory and strength tests. Mr. Patterson's thenar strength gave way to weakness bilaterally. Allen's testing and thoracic outlet stressing were normal. His grip strength measured 60 pounds on the right and 16 pounds on the left. Pinch strength measured 20 pounds on the right and 16 pounds on the left. Two-point discrimination was normal on the right and abnormal in four of the five digits on the left. Monofilament testing showed mild abnormalities in the right middle finger at 3.6 and moderate abnormalities in the right little finger at 4.3. Two-point discrimination testing also was performed by Kathryn Leindecker of Shoreline Physical Therapy Services, yielding similar results.

Dr. Wainright reviewed the Claimant's medical records, noting that the nerve conduction studies done by Dr. Moalli in November 1995 were normal.

Dr. Wainright concluded that Mr. Patterson has ongoing signs and symptoms of peripheral nerve entrapment. He noted that the medical records indicate the Claimant's symptoms began in 1995, but that he reported they started in 1993. Assuming Mr. Patterson's symptoms began in 1993, Dr. Wainright apportioned one-third of the injuries to his work at Electric Boat, and the remainder to his use of his hands after leaving Electric Boat. Regarding the left wrist condition, Dr. Wainright believed the injury happened after Mr. Patterson left Electric Boat, as there was no mention of the problem before that time.

The Employer submitted a report by Dr. Wainright, dated March 29, 2005, in which Dr. Wainright reviewed Mr. Patterson's recent medical records. (EX 3) Dr. Wainright reported Mr. Patterson's medical history, noting that he had nerve conduction studies on October 8, 2002, which were abnormal and showed evidence of a mild bilateral median mononeuropathy and a mild ulnar neuropathy at the left elbow. In

addition, C7 radiculopathy was found bilaterally. Because the Claimant's nerve conduction studies performed in 1995 were normal, Dr. Wainright felt that the Claimant's condition continued after he left Electric Boat.

Dr. Wainright noted that after going through unsuccessful conservative treatment, the Claimant underwent surgery for carpal tunnel treatment bilaterally. Post-op, he continued to have symptomatic complaints. Dr. Cherry followed the Claimant and assigned a 5% impairment of the right hand or arm and a 14% impairment of the left hand or arm.

Dr. Wainright discussed Dr. Willetts' examination of Mr. Patterson on September 16, 2004, in which he assigned a 1% loss of the right upper extremity due only to sensory loss, and a 2% impairment due to sensory function loss of the ulnar nerve. Dr. Wainright agreed with Dr. Willetts' assignment of 3% impairment for loss of muscle strength.

Dr. Wainright had originally assigned a 1% impairment rating for Mr. Patterson's right upper extremity, which he increased to 5% for the surgical procedures performed on the Claimant's wrist and elbow. Because the left upper extremity exhibited more evidence of sensory loss and EMG findings supported motor loss, Dr. Wainright had originally assigned a 5% impairment due to ulnar nerve deficits, but he increased this to 8% due to the surgical procedures performed on Mr. Patterson's hand and elbow.

Dr. Wainright felt that Mr. Patterson's impairment should be apportioned over his work time at Electric Boat and his ensuing work, which, according to Dr. Wainright, required heavy and repetitive use of his arms. Because Mr. Patterson's symptoms began in 1993 and his maximum medical improvement was reached in 2004, Dr. Wainright allocated 30% of his impairment to Mr. Patterson's time at Electric Boat. Thus, in Dr. Wainright's opinion, approximately 1.5% of the right upper extremity impairment and 2.5% of the left upper extremity impairment should be apportioned to Electric Boat.

Neurological Group

Dr. J.N. German of the Neurological Group examined Mr. Patterson on May 26, 1995. (CX 2 at 12) Mr. Patterson reported numbness in his hands that had been ongoing for several months. His hands sweat constantly, and pain extended from his hands up to his shoulder; he had numbness and tingling. Examination revealed a mild hypesthesia of the thumb, index and middle fingers on both hands. Mr. Patterson had a fairly markedly positive Tinel's sign at the right wrist, minimally on the left. He exhibited no evidence of muscle atrophy and his opponens pollicis was strong. Mr. Patterson had normal range of motion. Dr. German concluded that Mr. Patterson had bilateral carpal tunnel syndrome, and he instructed him to wear his wrist brace at all times.

A handwritten note in Mr. Patterson's records, dated November 7, 1995k, appears to document the results of Mr. Patterson's nerve conduction studies, which were normal, with no evidence of significant median or ulnar lesion. (CX 2 at 13)

Electric Boat Yard Hospital

Mr. Patterson went to the Electric Boat Yard Hospital on May 4, 1995 to report an injury from March 30, 1995. (CX 3 at 15) He reported that his repetitive work with a Burr machine, needle guns and blasting, and vibratory machines, had caused him pain in his hands. He was referred to a physician for examination.

Mr. Patterson returned to the Yard Hospital on May 12, 1995. (CX 3 at 16-17) He reported a one year history of broad numbness and pain in the previous two months and bilateral right epicondyle pain. Vibratory tests were administered and resulted in negative readings. Mr. Patterson was instructed to continue his present therapy and follow up with Dr. Moalt or Occupational Health. He was encouraged to quit smoking and lose weight.

Issue

The only issue to be decided in this case is the nature and extent of the Claimant's disability.

Stipulations

1. The Act applies to this claim.
2. The injury occurred on March 30, 1995 in Groton, Connecticut.
3. There was an employer/employee relationship at the time of the injury.
4. The injury arose out of and in the course of the worker's employment with the Employer.[4]
5. The claim was timely noticed and timely filed.
6. The Claimant is entitled to compensation and medical benefits.
7. The Claimant reached maximum medical improvement on May 13, 2004.
8. The Claimant's average weekly wage at the time of the injury was $777.48.
9. The Claimant's injury is a permanent partial disability.

DISCUSSION

Extent of the Claimant's Disability

The parties have stipulated, and the record supports the conclusion that Claimant suffers from a permanent partial disability to his right and left arms as a result of his March 30, 1995 injury. What remains to be determined is the extent of that partial disability, a dispute that centers on conflicting conclusions from the medical experts.

Dr. Cherry, Mr. Patterson's treating physician, first saw him in 1995 for his carpal tunnel symptoms. Mr. Patterson returned to him five years later, and eventually

[4] While the Employer originally disputed this issue, *see* Pretrial Statement of Electric Boat Corporation, March 15, 2005, the Employer submitted revised stipulations on May 11, 2005.

underwent surgery to relieve his pain. After both surgeries, Dr. Cherry concluded that Mr. Patterson continued to have impairment on both sides, with some improvement on the right. Based on continued positive Tinel's signs, decreased muscle bulk, decreased grip strength, and left-sided nerve irritation, Dr. Cherry assigned the Claimant's right upper extremity a 9% permanent partial impairment and the left upper extremity a 14% permanent partial impairment.

Dr. Willetts examined Mr. Patterson once, after his surgery, and noted his continued sensory and muscular complications. Contrary to Dr. Cherry's findings, Dr. Willetts noted no atrophy. However, he noted decreased pinprick sensation and positive carpal tunnel tests. Dr. Willets relied on the AMA Guides in concluding that Mr. Patterson's permanent partial impairment was limited to 6% for the right upper extremity and 9% for his left upper extremity.

Dr. Wainright examined the Claimant once, before his surgery, noting normal range of motion and normal tissue bulk. Mr. Patterson's elbow flexion test, Tinel's sign, and Phalen's test were all positive. Dr. Wainright also noted abnormal strength testing. He made no determination of impairment rating.

More recently, Dr. Wainright reviewed Mr. Patterson's medical records, noting the continuation of his condition from 1995 to the present. Based on Dr. Willetts' exam of Mr. Patterson and Dr. Tauro's nerve conduction studies, Dr. Wainright believed there was no muscle impairment to the right upper extremity, and assigned the Claimant's right upper extremity a 5% impairment. Because Dr. Willetts' exam of Mr. Patterson's left side revealed sensory loss, Dr. Wainright assigned a 5% permanent partial impairment of the left side, but increased this to 8% because the impairment involved Mr. Patterson's hands and elbows.

After examination of the medical evidence, and considering the arguments made in the parties' briefs, I have accepted the impairment ratings provided by Dr. Cherry. In *Piertrunti v. Director, OWCP*, 119 F.3d 1035, 1042-43 (2nd Cir. 1997), the United States Court of Appeals for the Second Circuit, in which this case arises, found that the opinion of a claimant's treating physician is to be accorded greater weight by the administrative law judge when deciding the existence and nature of the disability. Likewise, the Ninth Circuit has stated "[w]e afford greater weight to a treating physician's opinion because 'he is employed to cure and has a greater opportunity to know and observe the patient as an individual.'" *Amos v. Director, OWCP*, 153 F.3d 1051, 1054 (9th Cir. 1998), amended 164 F.3d 480 (9th Cir. 1999) (internal citations omitted).[5]

[5] After the Second Circuit's opinion was issued, the Board rejected a strict application of the treating physician rule. *O'Kelley v. Department of the Army/NAP*, 34 BRBS 39, 42 (2000). The Board held that the administrative law judge is required to independently analyze and discuss all the evidence before him and in so doing is entitled to evaluate credibility and draw inferences from the evidence. *Id*; *see also Reddick v. Chater*, 157 F.3d 715, 725 (9th Cir. 1998).

As the Claimant's treating physician, Dr. Cherry treated the Claimant's upper extremity conditions over a period of several years. His status as the Claimant's treating physician allowed him to observe the Claimant's symptoms and condition over a long period of time, both before and after surgery. His conclusions are supported by the results of his examinations over a period of time, as well as the results of objective testing. On the other hand, Dr. Willetts only examined the Claimant once, and he did not review the Claimant's longitudinal medical history as reported by Dr. Cherry. Dr. Wainright only examined the Claimant before his surgery, and he relied heavily on the records of other physicians to make his impairment determination.

I find that Dr. Cherry's opinions are entitled to more weight, not merely because he is the Claimant's treating physician, but because his status as the treating physician put him in a position to observe the Claimant's symptoms over a period of time, to make clinical findings, and to correlate those results, as well as the results of objective testing, with the Claimant's reports of symptoms. His conclusions are well reasoned, and amply supported by the objective medical evidence, and I accord them determinative weight.

Nor do I find that it was necessary for Dr. Cherry to discuss the Guides. The Board has held that "[b]ecause the Act does not require adherence to any particular guide or formula, the administrative law judge was not bound by the doctor's opinion nor was he bound to apply the Guides." *Mazze v. Frank J. Holleran, Inc.*, 9 BRBS 1053, 1055 (1978). An administrative law judge has significant discretion in determining the proper percentage for loss of use. *Michael v. Sun Shipbuilding & Dry Dock Co.*, 7 BRBS 5 (1977).

Dr. Cherry examined the Claimant on several occasions and was careful to make his impairment rating after the Claimant had recovered from surgery, and after obtaining appropriate test results. Consequently, I find Dr. Cherry's opinion is the better and more reliable evaluation of the Claimant's impairment. Accordingly, I find that the Claimant's permanent partial upper extremity disabilities are reasonably rated at 9% on the right and 14% on the left.

Apportionment of the Injury

The Employer contends the Claimant's injuries should be apportioned between the time he worked at Electric Boat and his activities thereafter. Employer's Brief, 2-4. The Employer argues that, because years have passed since Mr. Patterson's first complaints of carpal tunnel syndrome, Dr. Cherry failed to apportion the Claimant's injuries. *Id.*

The Act does not address the apportionment of injuries. However, it does discuss aggravation of injuries. The crucial question is whether the Claimant's condition is due to the aggravation, acceleration or exacerbation of a pre-existing condition, in which case a new injury has been sustained, or whether the condition is the natural and unavoidable consequence of a previous work-related injury, in which case the employer at the time of that injury is responsible for any and all benefits awarded.

Section 20(a) of the Act provides the Claimant with a presumption that the disabling condition is causally related to employment, if it is shown that the Claimant suffered a harm and that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the condition. *Gencarelle v. General Dynamics Corp.*, 22 BRBS 170 (1989), *aff'd*, 892 F.2d 173, 23 BRBS 13 (CRT) (2d Cir. 1989). Once the Claimant has invoked the presumption, the burden shifts to the Employer to rebut the presumption with specific and comprehensive medical evidence severing the connection between such harm and the Claimant's employment. *See James v. Pate Stevedoring Co.*, 22 BRBS 271 (1989). If the presumption is rebutted, the Court must weigh all the evidence and render a decision supported by substantial evidence. *See Del Vecchio v. Bowers*, 296 U.S. 280 (1935).

Both parties agree that Mr. Patterson is entitled to the presumption granted by section 20(a), as they have conceded that his injury is related to his employment at Electric Boat. Thus, the burden falls to the Employer to rebut the presumption that this injury is related to Mr. Patterson's employment by severing the connection between the injury and his employment. I find that the Employer has failed to rebut the presumption.

Dr. Willetts discussed Mr. Patterson's activities at Electric Boat. (EX 1 at 3) He pointed out that at his subsequent job, the Claimant performed some needle gun and sandblasting work, but only for one month out of a five year period. (EX 1 at 3) Mr. Patterson also occasionally used a chain saw, but not since accidentally amputating his left index finger. (EX 1 at 3) Dr. Willetts apportioned 2% of Claimant's 7% right upper extremity impairment and 4% of Claimant's 9% left upper extremity impairment to activities unrelated to Electric Boat.

Likewise, Dr. Wainright indicated that Mr. Patterson exercised "heavy and repetitive use of the hands and upper extremities" since he left Electric Boat. (EX-3 at 17) He reported that Mr. Patterson's symptoms were "progressive." (EX 3 at 17) Comparing Mr. Patterson's 1995 nerve conduction studies to his abnormal 2002 studies, Dr. Wainright stated that "[t]his speaks to the continuation of his injury after leaving Electric Boat." (EX 3 at 17) According to Dr. Wainright "[a]fter leaving Electric Boat, [Mr. Patterson's] symptoms and findings continued to progress." (EX 3 at 19)

I find that the evidence presented by the Employer is insufficient to overcome the presumption of section 20(a). First, nothing in the reports of Drs. Willetts or Wainright indicates that any event occurred that would break the causal chain between the Claimant's injury and his employment at Electric Boat. There is no mention of any accident or event that could have aggravated, accelerated or exacerbated Mr. Patterson's condition. *See Merrill v. Todd Pacific Shipyards Corp.*, 25 BRBS 140 (1991) (affirming an ALJ's decision that back pain experienced while doing yard work at home, potentially aggravating a prior work-related low back injury, was not an intervening, non-compensable injury but a natural and unavoidable consequence of the work-related injury.). In fact, the language used by Dr. Wainright suggests that Mr. Patterson's current condition is a *continuation* of the injury incurred at Electric Boat, indicating that his

symptoms are a natural progression of his ailment. Further, Dr. Willetts' report contradicts Dr. Wainright's contention that the Claimant exercised "heavy and repetitive use of the hands and upper extremities" by pointing out that the Claimant only performed needle gun work for one month and occasionally used a chain saw. These varying and conclusory reports of Mr. Patterson's work after leaving Electric Boat are equivocal, and insufficient to meet the Employer's burden.

Additionally, the conclusory statements in the reports of Drs. Willetts and Wainright are uncorroborated hearsay. There is no specific or comprehensive evidence in the record regarding the type of work done by the Claimant after he left Electric Boat, other than the statements made by Drs. Willetts and Wainright. Their reports do not provide the source of their information regarding Mr. Patterson's subsequent work, his use of his arms or hands, or his exposure to aggravating conditions. It is unclear whether these doctors were speculating about Mr. Patterson's tasks at work, or whether Mr. Patterson told them that his work involved exposure to aggravating movements. I find that these statements are woefully insufficient to sever the connection between the Claimant's condition and his work-related injury, and therefore the Employer has failed to rebut the presumption that Claimant's injury was caused by his employment at Electric Boat.

CONCLUSION

Based on the foregoing, I find that Claimant has established that he is permanently and partially disabled due to his upper extremity injuries, and that he is thus entitled to permanent partial disability payments commencing July 26, 2000.

ORDER

On the basis of the foregoing, the Claimant's request for disability compensation is granted.

Employer shall:

A. For the period of May 30, 1995 to May 13, 2004, pay to the Claimant temporary partial compensation benefits for his 9% permanent partial disability of the right upper extremity and for his 14% permanent partial disability of the left upper extremity, based on an average weekly wage of $777.48.

B. Commencing on May 13, 2004 and continuing, pay to the Claimant compensation benefits for his 9% permanent partial disability of the right upper extremity and for his 14% permanent partial disability of the left upper extremity, based on an average weekly wage of $777.48.

C. Receive credit for all amounts previously paid to Claimant as a result of his injuries of May 30, 1995.

D. Pay to the Claimant all medical benefits to which he is entitled under the Longshore and Harbor Workers' Compensation Act.

E. Pay to the Claimant's attorney fees and costs to be established by a supplemental order.

F. The District Director shall perform all calculations necessary to effect this Order.

SO ORDERED.

A

LINDA S. CHAPMAN
Administrative Law Judge